Little Sisters *of the* Poor
St. Joseph's Home for the Aged
1503 Michaels Road
Henrico, VA 23229
msrichmond@littlesistersofthepoor.org
804-288-6245

Tuesday, March 29, 2016

Ms. Elaine Cacciatore
LTC Supervisor
Commonwealth of Virginia
Department of Health
Office of Licensure and Certification
Division of Long Term Care Services
9960 Mayland Drive, Suite #401
Richmond, Virginia 23233

Dear Ms. Cacciatore,

The intent of this letter is to submit the "Plan of Correction" rectifying our deficiencies regarding the survey of March 10, 2016. The results of this survey were very unfortunate for a home operated by the Little Sisters of the Poor.

We move forward correcting our deficiencies and will do our utmost to provide "Quality of Care", a clean and a safe environment enabling our Residents to complete their "Life's Journey" in peace, contentment and serenity.

Thank you for your careful time and attention to these matters. Additionally, should you have any further queries, please do not hesitate to contact me directly.

Respectfully submitted,

Mother Marie Edward Quinn

Mother Marie Edward Quinn lsp.
Administrator
Little Sisters of the Poor
#1701002152

State of Virginia

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 49E151 | A. BUILDING ______ B. WING ______ | 03/10/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LITTLE SISTERS OF THE POOR | 1503 MICHAEL ROAD<br>RICHMOND, VA 23229 |

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| F 000 | Initial Comments<br><br>An unannounced biennial State Licensure Inspection was conducted 3/8/2016 through 3/10/2016. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities.<br><br>The census in this 32 bed facility was 31 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents #1 through #12) and one closed Resident review (Resident #13). | F 000 | F 000 This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. | 04/20/16 |
| F 001 | Non Compliance<br><br>The facility was out of compliance with the following state licensure requirements:<br><br>This RULE: is not met as evidenced by:<br>The facility staff was not in compliance with:<br><br>12VAC5-371-210 Nurse Staffing<br>12VAC5-371-210 (F.1)<br><br>Based on staff interview and facility documentation review, the facility staff failed to ensure a certification was verified through the Department of Health Professions (DHP) prior to hire for 1 of 11 Certified Nursing Assistants.<br><br>Employee #16 who was a Certified Nursing Assistant (CNA) did not have a verified CNA certification in her employee file.<br><br>The findings included:<br><br>On 3/10/16 employee file reviews were conducted. The review revealed Employee #16, a CNA | F 001 | F 001 1. Employee #16 CNA certification was verified through DHP.<br><br>2. HRD/ HR assistant will audit current employee files to evaluate licensure through DHP.<br><br>3. HRD will review hiring procedures and retrain HR assistant on state licensure requirements prior to hire.<br><br>4. HRD/Designee will do weekly audits x4 and monthly x 3 months to verify license staff are currently licensed through DHP.<br><br>5. Corrective action will be completed by 04/20/2016 | 04/20/16 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sr. Marie Edward Quinn
TITLE: Administrator
(X6) DATE: 04/01/16

State of Virginia

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| F 001 | Continued From Page 1<br><br>rehired on 9/1/15, did not have a verified certification check through the DHP done prior to hire.<br><br>An interview was conducted with the Human Resources Manager (Admin-D) on 3/10/16 at 12:05 p.m. Admin-D was informed of the missing CNA verification. Admin-D presented a "Hiring Checklist" form which was incomplete for Employee #16. Admin-D stated "I just didn't complete it." "It (the verification) got missed."<br><br>On 3/10/16 at approximately 4 p.m., the Administrator and Director of Nursing were informed of the findings. No further information was presented by the facility staff.<br><br>The facility was not in compliance with the following cross referenced citations:<br><br>12VAC5-371-150 Resident Rights<br>12VAC5-371-150 (B.1) Cross Reference to F-241.<br><br>12VAC5-371-370 Maintenance and Housekeeping<br>12VAC5-371-370 (A) Cross Reference to F-252.<br><br>12VAC5-371-250 Resident Assessment and Care Planning<br>12VAC5-371-250 (A) Cross Reference to F-278.<br><br>12VAC5-371-250 Resident Assessment and Care Planning<br>12VAC5-371-250 (G) Cross Reference to F-280.<br><br>12VAC5-371-200 Director of Nursing<br>12VAC5-371-200 (B) Cross Reference to F-281.<br><br>12VAC5-371-220 Nursing Services | F 001 | 12VAC5-371-150 Resident Rights<br>12VAC5-371-150 (8.1) Cross Reference to F-241.<br><br>12VAC5-371-370 Maintenance and Housekeeping. 12VAC5-371-370 (A) Cross Reference to F-252.<br><br>12VAC5-371-250 Resident Assessment and Care Planning 12VAC5-371-250 (A) Cross Reference to F-278.<br><br>12VAC5-371-250 Resident Assessment and Care Planning 12VAC5-371-250 (G) Cross Reference to F-280.<br><br>12VAC5-371-200 Director of Nursing<br>12VAC5-371-200<br>(B) Cross Reference to F-281<br>12VAC5-371-220 Nursing Services | |

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| F 001 | Continued From Page 2<br><br>12VAC5-371-220 (A,B) Cross Reference to F-309.<br><br>12VAC5-371-370 Maintenance and Housekeeping<br>12VAC5-371-370 (A) Cross Reference to F-323.<br><br>12VAC5-371-220 Nursing Services<br>12VAC5-371-220 (A) Cross Reference to F-329.<br><br>12VAC5-371-340 Dietary and Food Service Program<br>12VAC5-371-340 (A) Cross Reference to F-371.<br><br>12VAC5-371-300 Pharmaceutical Services<br>12VAC5-371-300 (B) Cross Reference to F-431.<br><br>12VAC5-371-180 Infection Control<br>12VAC5-371-180 (A,C) Cross Reference to F-441.<br><br>12VAC5-371-370 Maintenance and Housekeeping<br>12VAC5-371-370 (A) Cross Reference to F-456.<br><br>12VAC5-371-360 Clinical Records<br>12VAC5-371-360 (E) Cross Reference to F-514. | F 001 | 12VAC5-371-220 (AB) Cross Reference to F-309.<br><br>12VAC5-371-370 Maintenance and Housekeeping 12VAC5-371-370 (A) Cross Reference to F-323.<br><br>12VAC5-371-220 Nursing Services<br>12VAC5-371-220 (A) Cross Reference to F-329.<br>12VAC5-371-340 Dietary and Food Service Program<br>12VAC5-371-340 (A) Cross Reference to F-371<br><br>12VAC5-371-300 Pharmaceutical Services<br>12VAC5-371-300 (B) Cross Reference to F-431<br><br>12VAC5-371-180 Infection Control<br>12VAC5-371-180 (A,C) Cross Reference to F-441<br><br>12VAC5-371-370 Maintenance and Housekeeping 12VAC5-371-370 (A) Cross Reference to F-456.<br><br>12VAC5-371-360 Clinical Records<br>12VAC5-371-360 (E) Cross Reference to F-514 | |

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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicaid standard survey was conducted 3/8/2016 through 3/10/2016. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey.<br><br>The census in this 32 certified bed facility was 31 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents #1 through #12) and one closed record review (Residents #13). | F 000 | | |
| F 167 SS=C | 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE<br><br>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.<br><br>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and facility documentation review, the facility staff failed to prominently display availability of survey results.<br><br>The 2015 survey report results were available for review, however, there was no signage displayed to direct residents, visitors or staff to where the | F 167 | F 167 1. Survey Results are prominently displayed. There is signage at the front desk stating where to view survey results and also there is a binder available at the front desk with survey results.<br><br>2. DON/designee will inform current residents of the location of the survey results by posting a sign at the front entrance desk. During admission each resident signs an acknowledgment that they have been informed of the location of the survey results.<br><br>3. DON/Designee will in service front desk personnel about the prominent display of survey results. | 04/20/16 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sr. Marie Edward Quinn
TITLE: Administrator
(X6) DATE: 04/01/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 167 | Continued From page 1<br>survey report was located.<br><br>The findings included:<br><br>On 3/10/16, a general observation tour of the facility was conducted with the Maintenance Director (Admin-C). The 2015 survey report results were observed in a clear plastic sleeve on the wall to the left of the first floor elevators. No signage was observed at the front entrance desk or on the nursing unit to direct residents, visitors or staff to where the survey results were posted.<br><br>On 3/10/16 at 4:25 p.m. the Director of Nursing (Admin-B) was informed of the findings. The facility staff did not present any further information. | F 167 | F 167 Continued from previous page<br><br>4. DON/designee will conduct random audits weekly x4 and then monthly x3 to evaluate prominent display of survey results. Results of the audits will be reviewed the the QA committee to determine the need for further audits and/or actions plans.<br><br>5. Corrective action will be completed by 04/20/2016 | |
| F 241 SS=D | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and clinical record review, the facility staff failed to provide a dignified living experience, for 2 residents (Resident's #10, & #11) in the survey sample of 13 residents,.<br><br>1. For Resident #10, the facility staff administered an insulin injection in the hallway while exposing the Resident's abdomen. | F 241 | F 241 1. Resident #10's insulin is being administered in their assigned room. Resident #11's medication is being administered in their assigned room.<br><br>2. The DON / Deisgnee will audit current residents to evaluate location of medication administration and the provision of a dignified living experience.<br><br>3. The DON/Deisgnee will in service LPN "B",all licensed nurses regarding the location medication administration and the provision of a dignified living experience . | 04/20/16 |

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2. For Resident #11, the facility staff administered the Resident's medications in the dining room on 3-9-16 during the breakfast meal, at the dining table with 2 other Residents present.

The Findings included:

1. Resident #10 was admitted to the facility on 3-27-12, and readmitted 10-6-14. Resident #10's diagnoses included; Type 1 Diabetes, altered mental status, chronic respiratory failure, Hypertension, and Hyperlipidemia.

The most recent Minimum Data Set, was a Quarterly Assessment with an Assessment Reference Date of 2-1-16, coded Resident #10 as having a Brief Interview of Mental Status score of 9, indicating mild to moderate cognitive impairment. In addition, the resident was coded as requiring extensive to total assistance of 1 to two staff members for activities of daily living such as transferring, dressing, and bathing.

On 3-8-16 at 5:02 p.m., two surveyors conducted an observation of Resident #10 during medication pour and pass administration. The Resident sat in a wheel chair in a communal living room with three other residents. Resident #10 was told by the Licensed Practical Nurse (LPN) B that she needed to give the Resident their insulin injection. After drawing up the insulin and preparing the injection, LPN B took Resident #10 down the adjoining hall approximately 50 feet, to a hallway bathroom. LPN B open the bathroom door, and pushed the Resident halfway into the bathroom, so that the front wheels of the wheel chair were in the bathroom, and the back wheels were still in the hallway. The bathroom door was propped open by the wheel chair and could not be closed.

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4. The DON/Deisgnee will conduct random audits weekly x4 and monthly x 3 months to evaluate the location of medication administration and the provision of a dignified living experience.

5. Corrective action will be completed by 04/20/2016

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LPN B pulled up the Resident's shirt exposing the Resident's abdomen and the top of an adult incontinent brief, and proceeded to pull down the right side of the incontinent brief, and give the insulin injection in Resident #10's lower right abdomen. LPN B then pulled the Resident's shirt back down and returned the Resident to the sitting room. Visitors, and residents were moving up and down the hallway during the injection administration.

On 3-9-16 a review was conducted of Resident #10's clinical record, revealing the following signed physician's order, "Novolog Solution 100 units/ml (milliliter) (insulin aspart) inject 6 units subcutaneously three times per day related to type 2 diabetes, give before each meal, hold if blood sugar is less than 100." The Resident's blood sugar was checked prior to administration of the insulin, and was 256.

Interviews were held on 3-9-16 at the end of day debrief at approximately 5:00 p.m., with the facility Administrator, and Director of Nursing (DON), and they were notified of the findings. The DON stated, "The Resident should not have been exposed." No further information was provided by the facility.

2. For Resident #11, the facility staff administered the Resident's medications in the dining room on 3-9-16 during the breakfast meal, at the dining table with 2 other Residents present.

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Resident #11 was a 98 year old who was admitted to the facility on 5-21-13. Resident #11's diagnoses included; Hypertension, Osteoporosis, Incontinence, Rheumatoid Arthritis, and Malignant Neoplasm of the Colon.

The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 2-13-16, coded Resident #11 as usually being able to understand and be understood by others. Resident #11's Brief Interview of Mental Status Score was 13, indicating no impairment, to mildly impaired cognition.

On 3-9-16 at 8:50 a.m., two surveyors conducted an observation of Resident #11 during morning medication pour and pass administration of multiple residents. The Resident sat in a wheel chair in the main dining room with 2 other Residents at the table. Resident #11 was leaving the dining room, and stated she was going to her room. Registered Nurse (RN) B told Resident #11 to stay at her table because she was going to bring medications to her there. RN B at no time asked Resident #11 where she wished to receive her medications, and did not offer to join her in her private room to administer them. RN B prepared 4 tablet medications and pushed one tablet from each of the 4 different 30 day multiple dose medication blister card, into a plastic 30 milliliter medication cup, and handed the blister card to surveyors. The card revealed a prescription from the pharmacy on each card, which was affixed to the front of the card that denoted the Resident's name, type, strength, dose, timing, expiration date, and special administration instructions for each medication. The 4 tablet medications that were administered were as follows;

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| F 241 | Continued From page 5<br>1. Amlodipine 5 mg (milligrams) one tablet (for blood pressure)<br>2. Lasix 40 mg one tablet (for blood pressure)<br>3. Senexon-s 8.6/50 mg one tablet (stool softener)<br>4. Tramadol 50 mg one tablet (for pain)<br>After preparing the medications at the medication cart in the hallway outside of the dining room, RN B returned to the dining room and handed the medication cup to Resident #11, who took them orally with 60 milliliters of water also prepared by RN B in a 120 milliliter plastic drinking cup. Visitors, and residents were moving around freely in the dining room, and the two table mates watched during administration of Resident #11 's medications.<br><br>On 3-9-16 a review was conducted of Resident #11 's clinical record, revealing that all four medications were given according to the signed physician's order, however, the Resident was not afforded the option of public scrutiny during medication administration.<br><br>Interviews were held on 3-9-16 at the end of day debrief at approximately 5:00 p.m., with the facility Administrator, and Director of Nursing (DON), and they were notified of the findings. The DON stated, "The Resident should not have been administered meds in the dining room, unless the Resident specifically requested that." No further information was provided by the facility. | F 241 | | |
| F 252 SS=D | 483.15(h)(1)<br>SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT<br><br>The facility must provide a safe, clean, comfortable and homelike environment, allowing | F 252 | F 252 1. The bathroom vent for two residents was cleaned immediately. | 04/20/16 |

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the resident to use his or her personal belongings to the extent possible.

This REQUIREMENT is not met as evidenced by:

Based on observation, and staff interview, the facility staff failed to maintain a clean bathroom air vent for 2 Residents, (Resident #5, and #6). Resident's #5, and #6 shared a bathroom, and it was observed on tour 3-8-16, and again on 3-9-16 to have an air vent entirely covered in dust to reveal a furry appearance.

The findings included:

On 3-8-16 during initial tour of the facility at 2:00 p.m., the shared bathroom of Resident's #5, and #6 was observed to have a single air vent that was entirely covered in dust to reveal a furry appearance. The air vent was touched by the surveyor, and a shower of dusty dry residue fell from the vent resembling snow.

On 3-9-16 the shared bathroom of Resident's #5, and #6 was again observed multiple times throughout the day. The air vent had not been cleaned and appeared exactly as it did the day before.

On 3-9-16 at 5:00 p.m., an interview was conducted with the Administrator and Director of Nursing at the end of day debrief. They were notified of the findings in the conference room. At the end of the meeting they left the room, and began going room to room to inspect the vents, and returned to the conference room stating they could not find the problem area. They were escorted by surveyors to the bathroom of

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2. Administrator / housekeeping supervisor audited current residents rooms to evaluate cleanness of vents.

3. Housekeeping supervisor in serviced housekeeping staff regarding cleaning vents.

4. Housekeeping supervisor/designee will conduct room inspection of vents weekly x4 then monthly x3. Results of the audits will be reviewed by the QA committee to determine the need for further audits and /or action plans.

5. Corrective action will be completed by 04/20/2016.

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LITTLE SISTERS OF THE POOR | 1503 MICHAEL ROAD RICHMOND, VA 23229 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 252 | Continued From page 7<br>Resident's #5, and #6, and the problem was identified. The Administrator and DON (Director of Nursing) stated to the surveyors it would be cleaned immediately.<br><br>On 3-10-16 the vent was clean. No further information was provided. | F 252 | | |
| F 278 SS=D | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement. | F 278 | F 278 1. MDS Coordinator has submitted a corrected MDS for resident #3 and #13.<br><br>2. MDS Coordinator /designee will audit MDS for correct coding before submission.<br><br>3. DON/designee will in service the MDS Coordinator on correct MDS coding.<br><br>4. DON/designee will do weekly random audits x4 to evaluate MDS coding for correctness then monthly x3 . Results will be reviewed by the QA committee to determine the need for further audits and /or action plans.<br><br>5. Corrective action will be completed by 04/20/2016. | 04/20/16 |

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This REQUIREMENT is not met as evidenced by:

Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure a complete and accurate Minimum Data Set/Resident Assessment Instrument (MDS/RAI) for 2 residents (Resident #13, Resident #3) in the survey sample of 13 residents.

1. For Resident #13, the facility staff failed to complete Section G of the Quarterly Assessment. The transfer and ambulation coding area was blank (Section G).

2. For Resident #3's quarterly MOS assessment, the facility staff failed to code the Vision and Functional Status sections accurately.

The Findings included:

1. Resident #13 was a 93 year old who was admitted to the facility on 4/21/14. Resident #13's diagnoses included Dementia with Behavioral Disturbance, Hypertenstion, and Chronic Kidney Disease.

On 3/9/16 a review was conducted of Resident #13's clinical record, revealing a Quarterly MOS dated 8/3/15. The transfer and ambulation coding area was blank (Section G).

On 3/10/16 an interview was conducted with the MOS Coordinator (RN A). She stated that she didn't know why the section wasn't coded. She further stated, "I sign overall meaning all areas are completed." No further information was

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received.

2. For Resident #3's quarterly MOS assessment, the facility staff failed to code Vision and Functional Status sections accurately.

Resident #3 was originally admitted to the facility on 9/23/14 and readmitted on 5/11/15 with the diagnoses of, but not limited to, vascular dementia, cerebrovascular accident (CVA-stroke) with aphasia (difficulty speaking) and dysphagia (difficulty swallowing), pseudobulbar affect (inappropriate involuntary laughing and crying due to a nervous system disorder).

The most recent Minimum Data Set (MOS) was a quarterly assessment with an Assessment Reference Date (ARD) of 2/1/16. The MOS coded Resident #3 with moderate cognitive impairment for daily decision making; required extensive assistance from staff for bed mobility; and was dependent on staff for transfers, dressing, eating, toileting, hygiene and bathing.

Review of Resident #3's quarterly MOS with the ARD of 2/1/16 revealed the following coding errors:

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| F 278 | Continued From page 10<br>Section B-Hearing, Speech, and Vision<br>Section B1000-Vision, did not have a code number to indicate if Resident #3 had the ability to see in adequate light. The facility staff marked the section with a dash (-). And,<br><br>Section G-Functional Status<br>Sections G0110-"C. Walk in room" and "D. Walk in corridor" had dashes (-) instead of a self-performance and support provided code.<br><br>On 3/9/16 at approximately 5:10 p.m., the Administrator and Director of Nursing were informed of the inaccurate MOS coding.<br><br>An interview was conducted on 3/10/16 with the Registered Nurse, MDS Coordinator (RN-A) at 2:15 p.m. Regarding the dashes on the MDS in the vision section, RN-A stated she was "Unable to get anything from her (the resident)." When asked about the ambulation (walking) coding, RN-A stated the "RNA (restorative nursing assistant) was thinking if she couldn't assess it or didn't occur to put a dash." Then stated "It should've been "Did not occur" which should have been coded as an 8/8. At 2:45 p.m. RN-A stated "Vision should've been coded as a 3." A code of "3" under the vision section means "Highly impaired-object identification in question, but eyes appear to follow objects."<br><br>No further information was provided by the facility staff. | F 278 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be | F 280 | F 280 1. The comprehensive care plan for resident # 3 and #7 was updated to include non-pharmaological approaches prior to administering the anti -anxiety medication (Atavan). | 04/20/16 |

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incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, and clinical record review, the facility staff failed for 2 residents (Resident #3 and #7) of 13 residents in the survey sample, to revise the comprehensive care plan.

1. For Resident #3, the facility staff failed to include in the comprehensive care plan, non-pharmacological approaches prior to administering the antianxiety medication, Ativan.

2. For Resident #7, the facility staff failed to include in the comprehensive care plan, non-pharmacological approaches prior to administering the antianxiety medication, Ativan.

The findings included:

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2. DON/designee will audit current patients care plans to evaluate non-pharmalogical approaches for anti - anxiety medications.

3. DON/designee will in-service MDS coordinator regarding the inclusion of non-pharmological approaches in care plans for patients on anti -anxiety medications.

4. DON/designee will audit care plans for inclusion of non-pharmacological approaches for patients on anti -anxiety medications. (Ativan)

5. Corrective action will be completed by 04/20/2016

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1, Resident #3 was originally admitted to the facility on 9/23/14 and readmitted on 5/11/15 with the diagnoses of, but not limited to, vascular dementia, cerebrovascular accident (CVA-stroke) with aphasia (difficulty speaking) and dysphagia (difficulty swallowing), pseudobulbar affect (inappropriate involuntary laughing and crying due to a nervous system disorder),

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 2/1/16. The MOS coded Resident #3 with moderate cognitive impairment for daily decision making; required extensive assistance from staff for bed mobility; and was dependent on staff for transfers, dressing, eating, toileting, hygiene and bathing.

On 3/9/16 at 8:10 a.m. Resident #3 was observed in the entrance hallway in a tilt back wheelchair accompanied by her husband. When spoken to by the surveyor, Resident #3 yelled out ("ahhh" sound)and calmed when her husband told her it was okay.

On 3/9/16 at 9:05 a.m. Resident #3 was observed in her room in a tilt back wheelchair yelling out "ahhh" sounds. Licensed Practical Nurse-A (LPN-A) entered Resident #3's room and spoke with her. When LPN-A asked if she wanted to get back into bed, Resident #3 nodded her head "yes." Resident #3 was put into bed by 2 Certified Nursing Assistants via mechanical lift.

Resident #3's clinical record was reviewed on 3/9/16, The review revealed a physician orders which included:

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"Lorazepam (Ativan) Tablet 0.5 mg (milligrams) Give 0.5 mg via PEG-Tube (feeding tube) as needed for agitation and anxiety three times daily."

Review of the Medication Administration Record (MAR) revealed Resident #3 received the as needed Ativan 12 times in February 2016 and 2 times in March 2016.

Resident #3's care plan included the following focus areas and interventions:

Focus: "(Res #3 Name) has potential to demonstrate physical behaviors r/t (related to) Depression. Date Initiated: 02/06/2015."
Interventions: "Assess and anticipate (Res #3 Name) needs: comfort level, body positioning, pain etc. and give (Name) as many choices as possible about care and activities."

Focus: "(Name) uses psychotropic medications r/t adjustment disorder with mixed disturbance of emotions and conduct. Date Initiated: 09/23/2014."
Interventions: "Administer medications as ordered. Monitor/document for side effects and effectiveness. Consult with pharmacy, MD (medical doctor) to consider dosage reduction when clinically appropriate. Monitor/record/report to MD prn (as needed) side effects and adverse reactions ..."

Resident #3's care plan did not include non-pharmacological approaches to attempt prior to administering the as needed Ativan.

On 3/10/16 at 3:45 p.m., an interview was conducted with the Director of Nursing (Admin-B).

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When asked what she expected to be done prior to nursing staff giving as needed Ativan, Admin-B stated "Try calming down, try to see what's causing agitation, pain, wet repositioned."

On 3/10/16 at approximately 4:00 p.m., the Administrator and Director of Nursing were informed of the lack of non-pharmacological approaches in Resident #3's care plan. The facility staff did not present any further information regarding the findings.

2. Resident #7 was admitted to the facility on 10/28/13 with the diagnoses of, but not limited to, dementia, depression, anxiety, and chronic obstructive pulmonary disease (COPD).

The most recent Minimum Data Set (MOS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/30/15. The MOS coded Resident #7 with moderate cognitive impairment; required extensive assistance from staff for bed mobility, dressing, hygiene and bathing; required limited assistance from staff for transfers and toileting; and required set up assistance for ambulation and eating.

On 3/10/16 at 9:25 a.m., Resident #7 was observed sitting in a lounge chair in the hallway outside her room. She was alert and conversational. The restorative nursing assistant approached Resident #7 and asked if she wanted to exercise. Resident #7 stated "yes" and proceeded to stand up with the aid of her walker and walk with the nursing assistant.

Resident #7 clinical record was reviewed on

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| F 280 | Continued From page 16<br><br>On 3/10/16 at approximately 4:00 p.m., the Administrator and Director of Nursing were informed of the lack of non-pharmacological approaches in Resident #7's care plan. The facility staff did not present any further information regarding the findings. | F 280 | | |
| F 281 SS=E | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to follow the professional standards of nursing for 2 residents (Resident #2, Resident #5) in the survey sample of 13 residents.<br>1. For Resident #2, the facility staff failed to clarify an order regarding blood sugar parameters and administering oral anti-diabetic medications.<br>2. For Resident #5, the facility staff failed to obtain or clarify a physician's order for the amount of oxygen to administer.<br><br>The Findings included:<br>1. For Resident #2, the facility staff failed to clarify an order regarding blood sugar parameters and administering oral anti-diabetic medication administration.<br>Resident #2 was an 89 year old who was admitted to the facility on 1/9/13. Resident #2's diagnosis included Diabetes Mellitus, Hypertension, Breast Cancer, Bilateral Artificial | F 281 | F 281 1. Resident #2 orders were clarified. Resident # 5 orders were clarified.<br><br>2. DON/ designee will audit current resident with physician orders, for blood sugar perimeters, oral anti -diabetic medications & the amount of O2 to be administered. For clarity of orders.<br><br>3. DON/designee will in-service licensed staff on blood sugar perimeters and giving metformen with food. Also the proper clarification of O2 orders.<br><br>4. DON/designee will do weekly audits x4 followed by monthly x3 of physician orders for blood sugar, oral anti-diabetic medications and clarity of O2 orders. To evaluate the clarity of orders. Results of audits will be reviewed by QA committee to determine the need for further audits or action plans. | 04/20/16 |

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| F 281 | Continued From page 17<br>Hip Joints, and Left Artificial Knee Joint.<br>The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 2/29/16, coded Resident #2 as having a Brief Interview of Mental Status Score of 11, indicating mild cognitive impairment. She was also coded requiring the assistance of 1 staff person for ambulation. She was coded for requiring a wheelchair, which she could self-propel.<br>On 3/9/16 a review was conducted of Resident #2's clinical record, revealing the following signed physician's order, 2/1/16. "For Hypoglycemia (blood sugar 70 or below). Hold insulin & diabetic medication and contact physician Subconscious resident: Glucose Tablets 15 mg; or orange juice with 2 packets of sugar added; or Glucose gel 15 mg. (found in STAT box) Give every 15 minutes until blood sugar reaches 70. Semi-conscious residents: Glucose gel 15 mg - apply into corner of mouth every 15 minutes until blood sugar reaches 70. Glucagon injectable 1 uniU1 mg vial - call 911. Check blood sugar per schedule before breakfast and dinner two times a day for Diabetes Mellitus."<br>According to Resident #2's Medication Administration Records from February 1 thru March 8, 2016, Resident #2 received MetFormin HCl Tablet 1000 MG daily at 4:00 P.M. Resident #2's blood sugar were not checked prior to administering the medication. Because the order had not been clarified, staff only checked blood sugars before breakfast and dinner, and therefore had no way of knowing if the 4:00 P.M. medication should be held. Blood sugar levels were routinely checked at 5:00 P.M. before dinner.<br>On 3/9/16 The Director of Nursing (Administration B) stated that the physician would be asked to clarify the order. | F 281 | F281 Continued from previous page<br>5. Corrective action will be completed by 04/20/16 | |

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2. For Resident #5, the facility staff failed to obtain or clarify a physician's order for the amount of oxygen to administer.
Resident #5 was admitted to the facility on 2-27-15. Diagnoses included COPD (Chronic Obstructive Pulmonary Disorder), fibromyalgia, chronic pain syndrome, diabetes, dementia, osteoporosis, hypertension, gastro-esophageal reflux disease (GERO), anxiety, and depression.
Resident #S's most recent MOS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1-26-16 was coded as a quarterly assessment.
Resident #5 was coded a BIMS (Brief Interview of Mental Status) score of 12, indicating mild cognitive impairment. Resident #5 was also

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coded as needing limited assistance of one staff member for activities of daily living and as being always continent of bowel and occasionally incontinent of bladder.

On 3-9-16 a review of the clinical record was conducted revealing a current physician's order and MAR (Medication Administration Record) for administration of oxygen. The orders showed no documentation for the amount of oxygen to administer. The order was as follows;

"Oxygen via nasal cannula at L/min (Liters per minute) to keep oxygen saturation at or above 93% every shift, every day, Monday through Sunday." No dosage/amount of liters per minute was specified for treatment with the Oxygen for hypoxia.

"Hypoxia is a condition or state in which the supply of oxygen is insufficient for normal life functions.

In general, an individual patient ' s hypoxemia is usually diagnosed by oxygen monitors placed on fingers or ears (pulse oximeter) and/or by determining the oxygen level in a blood gas sample (a sample of blood taken from an artery ). Normal readings are about 94% to 99% oxygen saturation levels; generally, oxygen is supplied if the level is about 92% or below."

http://www. medicinenet.com/hypoxia_and_ hypoxemia/page3.htm

The Resident also required, and received Oxygen at bedtime, and overnight every night, at 2 Liters per minute via nasal cannula, as the Resident suffered from a diagnosis of Congestive Obstructive Pulmonary Disease (COPD) requiring Oxygen use.

A complete review of the clinical record did not reveal any documentation regarding the dosage of Oxygen needed for administration during hypoxia.

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On 3-10-16 at approximately 2:30 p.m. a telephone speaker interview was conducted with the attending doctor who certified Resident #1O's orders. 4 surveyors and the Director of Nursing and Administrator were present for the interview. The doctor stated that the Oxygen order should have been clarified by the nursing staff.
Resident #11 had not received the daytime ordered oxygen for hypoxia, however, it is likely that in the near future, the Resident will require this medication. Daily Oxygen saturation test results revealed a range of 93% to 95% (of a possible 100%) experienced by Resident #11 in the evenings every day during March 2016, and the order required use if Oxygen levels dipped below 93%.
On 3-10-16, After found by surveyors, and after the interview with the physician, the nursing staff received a new order for the dosage amount of Oxygen to administer to the Resident.
The Facility Policy on Medication Administration stated:
"All medications are administered by licensed nurses only in the Nursing Facility. ....... A physicians order that includes dosage, route, frequency, duration, and other required considerations is required for administration of medication. It is the responsibility of the nursing professional to be aware of the classification, action, correct dosage, and side effects of a medication before administration."
The facility cited Lippincott as the resource used for professional nursing standards. Guidance was given from Lippincott, Fundamentals of Nursing, which reads: "To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in

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| LITTLE SISTERS OF THE POOR | 1503 MICHAEL ROAD RICHMOND, VA 23229 |

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| F 281 | Continued From page 21<br>adhering to these rights:<br>1. The right medication<br>2. The right dose<br>3. The right patient<br>4. The right route<br>5. The right time<br>6. The right documentation"<br>Administration was informed of the findings on 3-9-16 at 5:00 p.m. at the end of day debrief, and again on 3-10-16. No further information was provided | F 281 | | |
| F 309 SS=E | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed for 3 residents (Resident #3, #7 and #2) of 13 residents in the survey sample to maintain their highest practicable well-being.<br>1. For Resident #3, the facility staff failed to attempt non-pharmacological approaches prior to administering the antianxiety medication, Ativan.<br><br>2. For Resident #7, the facility staff failed to attempt non-pharmacological approaches prior to administering the antianxiety medication, Ativan. | F 309 | F 309 1. Resident #3 and #7 were updated to include non-pharmacological approaches prior to administering the anti -anxiety medication. Resident #2's time on metformin was changed to 6 p.m. so that it can be given with food.<br><br>2. DON/designee will audit current resident care plans that are on anti - anxiety medications to evaluate individualized non-pharmacological approaches. The audit will also cover the timing of the administration of metformin.<br><br>3. DON/designee will in service licensed staff on non pharmacological approaches before administering the anti anxiety medication. The in service will also include training on the administration of metformin with food. | 04/20/16 |

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3. For Resident #2, the facility staff failed to administer Metformin (a diabetic medication) with food as required on 3-8-16.

The findings included:

1. Resident #3 was originally admitted to the facility on 9/23/14 and readmitted on 5/11/15 with the diagnoses of, but not limited to, vascular dementia, cerebrovascular accident (CVA-stroke) with aphasia (difficulty speaking) and dysphagia (difficulty swallowing), pseudobulbar affect (inappropriate involuntary laughing and crying due to a nervous system disorder).

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 2/1/16. The MDS coded Resident #3 with moderate cognitive impairment for daily decision making; required extensive assistance from staff for bed mobility; and was dependent on staff for transfers, dressing, eating, toileting, hygiene and bathing.

On 3/9/16 at 8:10 a.m. Resident #3 was observed in the entrance hallway in a tilt back wheelchair accompanied by her husband. When spoken to by the surveyor, Resident #3 yelled out ("ahhh" sound)and calmed when her husband told her it was okay.

On 3/9/16 at 9:05 a.m. Resident #3 was observed in her room in a tilt back wheelchair yelling out "ahhh" sounds. Licensed Practical Nurse-A (LPN-A) entered Resident #3's room and spoke with her. When LPN-A asked if she wanted to get back into bed, Resident #3 nodded her head "yes." Resident #3 was put into bed by 2 Certified

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3. (con't) the in service will also include training on the administration of metformin with food.

4. DON/designee will do weekly audits on patients on anti - anxiety medication(Ativan) / metformin weekly x4 and then monthly x3 . The results of the audits will be reviewed by the QA committee to determine the need for further audits and or action plans.

5. The corrective action will be completed by 04/20/2016

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Nursing Assistants via mechanical lift.

Resident #3's clinical record was reviewed on 3/9/16. The review revealed a physician orders which included:

"Lorazepam (Ativan) Tablet 0.5 mg (milligrams) Give 0.5 mg via PEG-Tube (feeding tube) as needed for agitation and anxiety three times daily."

Review of the Medication Administration Record (MAR) revealed Resident #3 received the as needed Ativan 12 times in February 2016 and 2 times in March 2016.

Resident #3's care plan included the following focus areas and interventions:

Focus: "(Res #3 Name) has potential to demonstrate physical behaviors r/t (related to) Depression. Date Initiated: 02/06/2015."
Interventions: "Assess and anticipate (Res #3 Name) needs: comfort level, body positioning, pain etc. and give (Name) as many choices as possible about care and activities."

Focus: "(Name) uses psychotropic medications r/t adjustment disorder with mixed disturbance of emotions and conduct. Date Initiated: 09/23/2014."
Interventions: "Administer medications as ordered. Monitor/document for side effects and effectiveness. Consult with pharmacy, MD (medical doctor) to consider dosage reduction when clinically appropriate. Monitor/record/report to MD prn (as needed) side effects and adverse reactions..."

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Resident #3's care plan did not include non-pharmacological approaches to attempt prior to administering the as needed Ativan.

Nursing Progress Notes included non-pharmacological approaches (repositioned, hand holding, brief changed, etc.) prior to administering the Ativan on the following dates and times:
2/3/16 at 10:09 p.m., 2/8/16 at 11:33 p.m., 2/9/16 at 11:50 p.m., 2/11/16 at 1:18 a.m., 2/13/16 at 7:43 p.m., 2/14/16 at 10:27 p.m., 3/5/16 at 12:05 p.m. and 3/6/16 at 4:56 p.m.

No non-pharmacological approaches were documented on the following dates and time:
2/5/16 at 11:45 a.m., 2/5/16 at 10:58 p.m., 2/6/16 at 5:42 a.m., 2/6/16 at 6:20 p.m., 2/8/16 at 2:30 p.m. and 2/10/16 at 3:57 p.m.

On 3/10/16 at 3:45 p.m., an interview was conducted with the Director of Nursing (Admin-B). When asked what she expected to be done prior to nursing staff giving as needed Ativan, Admin-B stated "Try calming down, try to see what's causing agitation, pain, wet repositioned."

On 3/10/16 at approximately 4:00 p.m., the Administrator and Director of Nursing were informed of the lack of non-pharmacological approaches prior to administering Ativan. The facility staff did not present any further information regarding the findings.

2. Resident #7 was admitted to the facility on 10/28/13 with the diagnoses of, but not limited to,

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dementia, depression, anxiety, and chronic obstructive pulmonary disease (COPD).

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/30/15. The MDS coded Resident #7 with moderate cognitive impairment; required extensive assistance from staff for bed mobility, dressing, hygiene and bathing; required limited assistance from staff for transfers and toileting; and required set up assistance for ambulation and eating.

On 3/10/16 at 9:25 a.m., Resident #7 was observed sitting in a lounge chair in the hallway outside her room. She was alert and conversational. The restorative nursing assistant approached Resident #7 and asked if she wanted to exercise. Resident #7 stated "yes" and proceeded to stand up with the aid of her walker and walk with the nursing assistant.

Resident #7 clinical record was reviewed on 3/10/16. The review revealed physician orders which included:

"Lorazepam (Ativan) Tablet 0.5 mg Give 1 tablet by mouth as needed for anxiety/insomnia Three times a day and at bedtime; Up to 3 am per Dr. (Name)."

Review of the Medication Administration Record (MAR) for March 2016 revealed Resident #7 received the as needed Ativan on 3/2/16 at 2146 (9:46 p.m.). Review of the Nursing Progress Notes revealed there were no non-pharmacological interventions attempted by the facility staff prior to administering the Ativan.

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Resident #7's care plan included the following focus areas and interventions:

Focus: "(Resident #7's Name) has a behavior problem r/t depression, anxiety, dementia with behavioral disturbances Date Initiated: 11/11/2013."

Interventions: "administer medications as ordered by physician...nurses to monitor and document sleep pattern, hallucinations, etc. as needed...Nuses (sic) to monitor and record behaviors..."

Resident #7's care plan did not include non-pharmacological approaches to attempt prior to administering the as needed Ativan.

On 3/10/16 at 3:45 p.m., an interview was conducted with the Director of Nursing (Admin-B). When asked what she expected to be done prior to nursing staff giving as needed Ativan, Admin-B stated "Try calming down, try to see what's causing agitation, pain, wet repositioned."

On 3/10/16 at approximately 4:00 p.m., the Administrator and Director of Nursing were informed of the lack of non-pharmacological approaches prior to administering Ativan. The facility staff did not present any further information regarding the findings.

3. For Resident #2, the facility staff failed to administer Metformin (a diabetic medication) with food, as required, on 3-8-16 during medication pour and pass observations.
For Resident #2, medication pour and pass observations were conducted by 2 surveyors on

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on 3-8-16 at 4:18 p.m.. Licensed Practical Nurse (LPN) B pushed one tablet from the 30 day multiple dose medication blister card, into a plastic 30 milliliter medication cup, and handed the blister card to surveyors. The card revealed a prescription from the pharmacy, which was affixed to the front of the card that denoted the Resident's name, type, strength, dose, timing, expiration date, and special administration instructions for the medication. The card had an orange sticker on it that stated "Take with food". The Medication was Metformin 1000 mg (milligrams) one tablet by mouth. LPN B administered the one oral Metformin tablet to Resident #2 at 4:18 p.m. with 60 milliliters of water in a 120 milliliter plastic cup. The Resident was sitting alone in her room during the observation. No food was given with the medication, and the Resident did not have the dinner meal until approximately 6:00 p.m. that evening.

Review and reconciliation of medication orders occurred on 3-9-16, and revealed a doctor's order for "Metformin Hydrochloride tablet 1000 mg give 1 tablet by mouth two times per day related to diabetes", ordered 1-9-13.

Metformin is a glucose lowering agent which begins to act within 1 hour of taking the medication. It is used for those individuals who have a diagnosis of Diabetes, and reference information was given by the U.S. Food and Drug Administration (FDA), and follows;

HOW should this medicine be used?

Metformin comes as a liquid, a tablet, and an extended-release (long-acting) tablet to take by mouth. The liquid is taken with meals one or two times a day. The regular tablet is taken with meals two or three times a day.

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| F 309 | Continued From page 28<br>The extended-release tablet is taken once daily with the evening meal.<br>To help you remember to take metformin, take it around the same time(s) every day. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Take metformin exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor.<br>On 3-9-16 at 5:00 P.M. the facility Administrator, and Director of nursing (DON) were notified of the findings. The DON stated, "The medicine should have been given with food". No further information was provided | F 309 | | |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility staff failed to ensure a hazard free environment.<br><br>An unlocked laundry chute which went from the first floor down to the ground level was observed during the General Observation of the facility. | F 323 | F 323 1. The lock on the door to the linen chute was installed on 3/21/16.<br>2. Maintenance will audit laundry chute door to evaluate lock placement.<br>3. DON/designee will in service CNA staff regarding the lock on the door to the laundry chute.<br>4. Maintenance /designee will do weekly audits x4 and then monthly x3 to evaluate lock placement on door. The results will be reviewed by the QA committee to determine the need for further audits or action plans.<br>5. The corrective action will be completed by 04/20/2016 | 04/20/16 |

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| F 323 | Continued From page 29<br>The findings included:<br><br>On 3/10/16 during a General Observation tour with the Maintenance Director (Admin-C) an unlocked linen chute door was observed behind an unlocked closet-type door on the first floor. The linen chute had a metal door with a turn knob used to open the door. There was a disengaged lock type button on the knob but no lock and key mechanism. The doors opened without difficulty. No residents were observed attempting to open the door or behind the door.<br><br>The linen chute exit was observed in the linen room which was one flight down on the ground level. There was an empty linen bin under and multiple empty bins around the linen chute. There were no residents observed in the linen room.<br><br>Review of facility incident and accident reports did not reveal any resident concerns regarding the linen chute.<br><br>On 3/10/16 at 4:00 p.m. the Administrator and Director of Nursing were informed of the unlocked linen chute. The chute opening was approximately 19 inches by 19 inches and accessible at wheelchair height.<br><br>The facility staff did not present any further information regarding the findings. | F 323 | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including | F 329 | F 329 1. Resident #3 care plan was updated with non-pharmocogical interventions. | 04/20/16 |

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duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and clinical record review, the facility staff failed for one resident (Resident #3) of 13 residents in the survey sample to ensure that Resident #3 was free from an unnecessary medication.

Resident #3 was administered the as needed antianxiety medication, Ativan, prior to attempting non pharmacological interventions.

The findings included:

Resident #3 was originally admitted to the facility on 9/23/14 and readmitted on 5/11/15 with the

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2. DON/Designee will audit current resident physician orders for anti - anxiety medications to evaluate the use and documentation of non - pharmacological interventions prior to administration of anti -anxiety medications (Ativan).

3. DON/Designee will in service licensed nurses ~~and med techs~~ regarding the use and documentation of non - pharmacological interventions prior to the use of anti -anxiety medications.

4. DON/designee will do a weekly audits x4 and then monthly x3 on patients with anti -anxiety medications to evaluate proper use and documentation of non pharmacological interventions before the use of anti -anxiety medications.

5. Corrective action will be completed by 04/20/2016

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diagnoses of, but not limited to, vascular dementia, cerebrovascular accident (CVA-stroke) with aphasia (difficulty speaking) and dysphagia (difficulty swallowing), pseudobulbar affect (inappropriate involuntary laughing and crying due to a nervous system disorder).

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 2/1/16. The MDS coded Resident #3 with moderate cognitive impairment for daily decision making; required extensive assistance from staff for bed mobility; and was dependent on staff for transfers, dressing, eating, toileting, hygiene and bathing. The MDS coded Resident #3 with "Other behavioral symptoms not directed toward others" and "Behavior of this type occurred 4 to 6 days, but less than daily."

On 3/9/16 at 8:10 a.m. Resident #3 was observed in the entrance hallway in a tilt back wheelchair accompanied by her husband. When spoken to by the surveyor, Resident #3 yelled out ("ahhh" sound)and calmed when her husband told her it was okay.

On 3/9/16 at 9:05 a.m. Resident #3 was observed in her room in a tilt back wheelchair yelling out "ahhh" sounds. Licensed Practical Nurse-A (LPN-A) entered Resident #3's room and spoke with her. When LPN-A asked if she wanted to get back into bed, Resident #3 nodded her head "yes." Resident #3 was put into bed by 2 Certified Nursing Assistants via mechanical lift.

Resident #3's clinical record was reviewed on 3/9/16. The review revealed a physician orders which included:

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"Lorazepam (Ativan) Tablet 0.5 mg (milligrams) Give 0.5 mg via PEG-Tube (feeding tube) as needed for agitation and anxiety three times daily."

Review of the Medication Administration Record (MAR) revealed Resident #3 received the as needed Ativan 12 times in February 2016 and 2 times in March 2016.

Resident #3's care plan included the following focus areas and interventions:

Focus: "(Res #3 Name) has potential to demonstrate physical behaviors r/t (related to) Depression. Date Initiated: 02/06/2015."
Interventions: "Assess and anticipate (Res #3 Name) needs: comfort level, body positioning, pain etc. and give (Name) as many choices as possible about care and activities."

Focus: "(Name) uses psychotropic medications r/t (related to) adjustment disorder with mixed disturbance of emotions and conduct. Date Initiated: 09/23/2014."
Interventions: "Administer medications as ordered. Monitor/document for side effects and effectiveness. Consult with pharmacy, MD (medical doctor) to consider dosage reduction when clinically appropriate. Monitor/record/report to MD prn (as needed) side effects and adverse reactions..."

Resident #3's care plan did not include non-pharmacological approaches to attempt prior to administering the as needed Ativan.

Nursing Progress Notes included

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| LITTLE SISTERS OF THE POOR | 1503 MICHAEL ROAD<br>RICHMOND, VA 23229 |

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non-pharmacological approaches (repositioned, hand holding, brief changed, etc.) prior to administering the Ativan on the following dates and times:
2/3/16 at 10:09 p.m., 2/8/16 at 11:33 p.m., 2/9/16 at 11:50 p.m., 2/11/16 at 1:18 a.m., 2/13/16 at 7:43 p.m., 2/14/16 at 10:27 p.m., 3/5/16 at 12:05 p.m. and 3/6/16 at 4:56 p.m.

No non-pharmacological approaches were documented on the following dates and times: 2/5/16 at 11:45 a.m., 2/5/16 at 10:58 p.m., 2/6/16 at 5:42 a.m., 2/6/16 at 6:20 p.m., 2/8/16 at 2:30 p.m. and 2/10/16 at 3:57 p.m.

On 3/10/16 at 3:45 p.m., an interview was conducted with the Director of Nursing (Admin-B). When asked what she expected to be done prior to nursing staff giving as needed Ativan, Admin-B stated "Try calming down, try to see what's causing agitation, pain, wet, repositioned."

On 3/10/16 at approximately 4:00 p.m., the Administrator and Director of Nursing were informed of the lack of non-pharmacological approaches prior to administering Ativan. The facility staff did not present any further information regarding the findings.

F 356 SS=C 483.30(e) POSTED NURSE STAFFING INFORMATION — F 356

The facility must post the following information on a daily basis:
o Facility name.
o The current date.
o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for

**Provider's Plan of Correction (F 356)** — Completion date: 04/20/16

F 356 1. Nursing staffing sheets are posted and the actual hours worked are indicated.

2. DON/Designee will audit the posting the posting of the nursing staffing sheet to evaluate that actual hours worked are totaled.

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resident care per shift:
- Registered nurses.
- Licensed practical nurses or licensed vocational nurses (as defined under State law).
- Certified nurse aides.

o Resident census.

The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:
o Clear and readable format.
o In a prominent place readily accessible to residents and visitors.

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility documentation review, the facility staff failed to adequately post nurse staff information.

The facility staff failed to post the "Actual Hours Worked" for the nursing staff for 3/9/16 and 3/10/16.

The findings included:

During general observations of the facility, a nursing staff information form was observed on the front entrance desk. The nursing staff form is

F 356 F 356 Continued from previous page

3. DON/Designee will in service 11-7 supervisor and scheduler on posted nursing staffing sheet and totaling actual hours worked.

4. DON/Designee will do a daily audit to evaluate that the nursing staffing sheet is posted and that the actual hours worked is totaled x 4 week and and monthly x 3 . The results will be reviewed by the QA Committee to determine if further audits are needed and /or action plans.

5. Corrective action will be completed by 04/20/2016

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| F 356 | Continued From page 35<br>used to inform residents, visitors and staff of how many Registered Nurses, Licensed Practical Nurses and Certified Nursing Assistants are working on their respective shifts. There were 5 columns with the following titles on the form:<br><br>"SHIFT;<br>ACTUAL HOURS WORKED;<br>NUMBER OF STAFF PER-SHIFT TOTAL;<br>24 HOURS STAFF TOTAL;<br>RESIDENT CENSUS."<br><br>On 3/9/16 and 3/10/16, the "Actual Hours Worked" column was blank.<br><br>A request for the forms was made on 3/10/16. At 3:40 p.m. on 3/10/16 the Director of Nursing (Admin-B) presented the forms with the "Actual Hours Worked" filled in. When asked when the hours were added, Admin-B stated "I just totaled them." It was discussed that the information was not documented prior to Admin-B completing the form. No further information was provided by the facility staff. | F 356 | | |
| F 371 SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions | F 371 | F 371 1. Trash can lids were placed on trash cans. The dietary aide was educated on taking temp's on all food items.<br><br>2. Administrator /DON did walking rounds on large trash cans to evaluate that lids were present.<br><br>3. DON/Designee will in service dietary aides on the proper temperature taking procedure, The in service will also cover the proper use of trash can lids. | 04/20/16 |

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This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, and facility documentation review, the facility staff failed to prepare and serve food in a sanitary manner.

The facility staff failed to cover trash cans, and failed to take food temperatures.

The Findings included:

On 3/8/16 at 1:15 P.M. an observation was made of the facility kitchen. There were 3 very large, uncovered trash cans. There were no lids in the kitchen. All of the trash cans were about half filled with garbage.

On 3/9/16 at 12:00 Noon an observation was conducted of the tray line which was conducted in the dining room. The Dietary Aide (Other C) took the temperature of the tuna salad (40 Degrees), Penne Pasta Marinara (148.5 Degrees), Baked Chicken (150.5 Degrees), Mashed Potatoes (146. Degrees), Collard Greens (177.8 Degrees Fahrenheit) She did not take the temperatures of the following foods: Fortified Potato, Gravy, Mechanically chopped Chicken, Potato Salad, and various chopped fruits.

It was noted that Other C used a dry ripped cloth to wipe the thermometer after each measurement was taken.

The facility did not have a policy on food temperatures. The facility submitted a log of the food temperatures. The log did not list all of the foods that were served. The log contained enough empty spaces for all of the foods to be listed.

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4. DON/Designee will audit weekly x4 and monthly x3 of dietary aides taking food temputures and using trash can lids. Results of audits will be reviewed by the QA committee to determine if further audits and /or plans of correction are needed.

5. The corrective action will be completed by 04/20/16

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| F 371 | Continued From page 37<br><br>It was noted that the facility did not have any gastrointestinal outbreaks.<br><br>On 3/9/16 at 12:20 P.M. an interview was conducted with Other C, when asked why she didn't take the temperatures of all of the food, she stated, "I just usually do one food."<br><br>On 3/10/16 the facility Administrator showed the surveyor the sanitary wipes that were supposed to be used to clean the thermometer. She further stated that Other C told her that she used "the rag" and didn't clean it properly after measuring the temperature of each food. | F 371 | | |
| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to | F 431 | F 431 1. Expired medications were disposed of by the nurse.<br><br>2. DON/Designee audited all med rooms, treatment carts and med carts to evaluate for expired medications, and altered labels.<br><br>3. DON/Designee will in service nursing staff on the proper disposal of expired medications. In servicing will also cover the non use of adulterated labeled medications.<br><br>4. DON/Designee will conduct random audits weekly x4 weeks and then monthly x 3 months to evaluate for expired medications. Results of audit will be reviewed by the QA Committee to determine the need for further audits / action Plan. | 04/20/16 |

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have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

Based on observation, and staff interview, facility staff failed to ensure an expired medication was not available for use, and failed to ensure a drug pharmacy prescription label was unadulterated, in one of two medication rooms.

The findings included:

On 3-9-16 at approximately 2:00 p.m., the medication room on Unit One was inspected. The medication room contained a tube of Nitroglycerin ointment, which expired February 2016, and was open and available for use. The label was torn and the Resident's name was obscured and not visible. Also found was a eye drop bottle of Systane eye drops, which were open and available for use, on which the label had been colored in with a permanent black marker so as not to be able to read the prescription. No open date was written on the bottle. Registered Nurse (RN) B was present during the medication room inspections, and stated "I think this Nitroglycerin belongs to

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5. Corrective action will be completed by 04/20/2016

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| F 431 | Continued From page 39<br>.....name, and the eye drops belong to ......name, but I can't be sure." Both medications were discarded by the nurse.<br><br>On 2-24-16, the Administrator and DON (director of nursing) were notified of the above findings. The DON stated expired medications should be discarded, and no prescription should ever be altered. No further information was provided. | F 431 | | |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their | F 441 | F 441 1. Resident #2, #7, #9, #10 and #12's medications are being administered in accordance with proper hand hygiene. Infection control program maintained<br><br>2. DON/designee will audit current residents during medication administration to evaluate hand hygiene practices of of licensed staff . DON/Designee will review current infection control program and implement program designed to comply with current CDC requirements.<br><br>3. DON/designee will in service LPN "B", RN "B" and all licensed staff regarding hand hygiene practices during medication passes. DON/ designee will in service the ADON on the infection control program. | 04/20/16 |

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hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility documentation review, the facility staff failed to perform hand hygiene between 6 Resident contacts (Resident's #2, 7, 8, 9, 10 and 12) during medication administration, and failed to maintain an infection control program.

Staff assisted Residents with medications and did not perform hand hygiene between Resident contacts, and had no working infection control program.

The findings included:

On 3-8-16, and 3-9-16, during Medication pour and pass observations, the following observations were made:

On 3-8-16, beginning at 4:00 p.m., Licensed Practical Nurse (LPN) B administered medications to Resident's #2, #7, #8, and #9 without wearing gloves. The nurse did not wash her hands, between contact, with each individual. The Observation follows:

LPN B handed the 30 milliliter (ml) plastic pill

F 441 F 441 Continued from the previous page

4. DON/designee will conduct random audits weekly x4 and then monthly x3 months to evaluate the infection control program and for proper hand hygiene practices during medication passes. The results of the audit will be reviewed by the QA committee to determine the need for further audits action plans.
5. Corrective action will be completed by 04/20/2016.

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cups with medications she had prepared to each Resident, accompanied by a 120 milliliter plastic drinking cup with water in it, to each resident, as she administered medications.

LPN B would prepare the medications for 1 resident at a time, and administer them before preparing medications for the next resident.

After each resident was finished pouring pills into their mouths from the pill cups, (while touching the pill cups to their mouths), and swallowing the medications by drinking the water (while touching the drinking cups to their mouths), the residents would hold the cups out to the nurse to be removed and discarded by the nurse.

Licensed Practical Nurse (LPN) B retrieved the pill cups from the Residents by the rim of the cup (which had touched the residents mouth) and dropped it into the used drinking cup (which had touched the residents mouth), and held the drinking cup in her fingers by the rim (which had touched their mouths), and dropped them into the trash can affixed to the medication cart while holding the cup by the rim. LPN B would then prepare medications for the next Resident, touching the pill cards, bulk dose medication bottles, and the clean cup supply on the medication cart each time after her hands were contaminated. At no time during the medication pour and pass observation for Residents #2, #7, #8 and Resident #9, did LPN B wear gloves, or wash her hands between each of these Resident contacts.

LPN B did wash her hands in the prep kitchen sink for 10 seconds prior to assisting with feeding pudding to a resident in the hallway. The prep

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kitchen was located directly across from the dining room. LPN B did not wash her hands, nor did she wear gloves, after feeding the pudding to the resident, and throwing away the empty container, again retrieving it from the Resident by the rim which the resident had licked with her tongue upon opening.
LPN B then proceeded to obtain a fingerstick blood sugar and administer an insulin injection to Resident #10 without washing her hands, and after throwing away the dirty pudding cup.

On 3-9-16 beginning at 8:50 a.m. Registered Nurse (RN) B was observed assisting resident's eating breakfast in the dining room. Prior to administering medications to Resident #12, RN B washed her hands in the prep kitchen sink, directly across from the dining room for 10 seconds. RN B then prepared and administered Resident #12's medications.

All of the Residents involved in the failed hand hygiene practices were placed in the survey sample.

The Facility policy on handwashing was reviewed and stated that handwashing should occur for 10 to 15 seconds. This is a direct contradiction to the Centers for Disease Control (CDC) which sets the standard of infection control practices in the United States. The CDC recommendations are as follows:

"You should practice hand hygiene for greater than 20 seconds:
- Before preparing or eating food. .
- Before touching your eyes, nose, or mouth.
- Before and after changing wound dressings or bandages.

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. For All patients are at risk for hospitalization.

- After using the restroom. During infections.
- After blowing your nose, coughing, or sneezing.

After touching surfaces such as bed rails, bedside tables, doorknobs, remote controls, or the phone. Healthcare providers should practice hand hygiene: Every time they enter your room. Before putting on gloves. After removing gloves. Wearing gloves alone is not enough to prevent the spread of infection."

On 3-10-16, the infection Control Nurse (RN A) was interviewed, and was asked when it is appropriate to wash hands, and her response was, when hands are visibly soiled, before and after direct Resident contact, before and after assisting a resident with meals or medicines. Registered Nurse (RN) A was asked how long hands should be washed, and she stated 10 seconds. RN A was also interviewed regarding the infection control program, and was not able to answer what types of isolation precautions are currently in standardized use, and what personal protective equipment (PPE) would be appropriate for those individuals who were in isolation precautions for each group. She continued to say that facility staff practice was not being observed to ascertain if correct standards were being used by staff. When asked to see the tracking and trending of infections in the facility, she stated they would be starting that this month, and that the policies were going to be redone in April 2016. When asked what standard was used to base the infection control program on, she could not answer. She then stated that she was also responsible for Assistant Director of Nursing duties, and the MDS (Minimum Data Set)

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| F 441 | Continued From page 44<br>completion, and had to self- teach all of these things, which had taken a long time. RN A stated she had been employed by the facility for one year and a half, and was going to get the Infection Control program up and running in April 2016 (next month).<br><br>On 3-10-16 at 3:00 p.m., The Administrator, and Director of Nursing (DON) were advised of failure of the staff to perform hand hygiene after Resident contact during medication administration, and the failure to have an active infection control program, at the end of day debrief. No further information was provided. | F 441 | | |
| F 456 SS=E | 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION<br><br>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility staff failed to maintain equipment in an operating condition in 1 of 2 shower/tub rooms.<br><br>Shower room "401" did not have a functioning sink available for use.<br><br>The findings included:<br><br>On 3/10/16 at approximately 10:15 a.m. an inspection of shower/tub room "401" was conducted with the Maintenance Director (Admin-C). Near the toilet was a sink with a neck cutout used for hair washing. When the water | F 456 | F 456 1. The sink in the first floor shower room "401" was repaired and ready to be used by residents and staff on 03/15/2016.<br><br>2. DON/designee did a walking round on each unit to ensure all sinks are in good working order and safe operating condition.<br><br>3. DON/Designee will in service all nursing staff on the filling out of a maintenance request form and the procedure for maintenance notification when any equipment is not in proper working order.<br><br>4. Maintenance Supervisor/designee will do random weekly audits x4 to evaluate the safe working order of physical plant equipment and then monthly x3 months. Results will be reviewed by QA Committee | 04/20/16 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 49E151 | A. BUILDING ______<br>B. WING ______ | 03/10/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LITTLE SISTERS OF THE POOR | 1503 MICHAEL ROAD<br>RICHMOND, VA 23229 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 456 | Continued From page 45<br>valve was turned on, no water came out of the hose. There was a bath tub and shower area that had functioning water. There were no other sinks in the shower room. When asked how staff washed their hands, Admin-C stated "There's hand gel."<br><br>On 3/10/16 at 10:20 a.m., Certified Nursing Assistant-A (CNA-A) entered the shower room. When<br>CNA-A was asked how she washed her hands in the shower room, she stated "Use the shower faucet and get paper towel for hands or use hand gel."<br><br>On 3/10/16 at approximately 4:00 p.m., the Administrator and Director of Nursing were informed of the findings. At 4:30 p.m. when asked how would a resident would was their hands in the shower room, Admin-B stated they "Would need a working sink."<br><br>The facility staff did not present any further information regarding the non-functioning sink. | F 456 | F456 Continued from previous page<br><br>4. (Con't) to determine the need for further audits and /or action plans.<br><br>5. Corrective action will be completed by 04/20/2016 | |
| F 514<br>SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any | F 514 | F 524 1. Weight book binder was found on the nursing unit with resident #3's weight recorded in the proper area. Nurse was instructed to enter resident #3's weight as an addendum in the weight's section of the PCC<br><br>2. DON/designee will audit the weight book binders, to evaluate that the weights are transfered to the clinical record in the PCC. | 04/20/16 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 49E151 | A. BUILDING ______ B. WING ______ | 03/10/2016 |

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| LITTLE SISTERS OF THE POOR | 1503 MICHAEL ROAD RICHMOND, VA 23229 |

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F 514 Continued From page 46

preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed for one resident (Resident #3) of 13 residents in the survey sample to maintain a complete record.

For Resident #3, the facility staff failed to document physician ordered weights in the clinical record.

The findings included:

Resident #3 was originally admitted to the facility on 9/23/14 and readmitted on 5/11/15 with the diagnoses of, but not limited to, vascular dementia, cerebrovascular accident (CVA-stroke) with aphasia (difficulty speaking) and dysphagia (difficulty swallowing), pseudobulbar affect (inappropriate involuntary laughing and crying due to a nervous system disorder). Resident #3 received her medications and feedings through a feeding tube.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 2/1/16. The MDS coded Resident #3 with moderate cognitive impairment for daily decision making; required extensive assistance from staff for bed mobility; and was dependent on staff for transfers, dressing, eating, toileting, hygiene and bathing.

On 3/9/16 at 11:30 a.m., Resident #3's clinical record was reviewed. The review revealed a

F 514 F 514 Continued from previous page

3. DON/Designee will in service nursing staff, and CNA's on the proper documentation and recording of weights.

4. DON/Designee will do a weekly audit x4 followed monthly x3 to evaluate the patients weights are documented in the clinical record. The results will be reviewed by the QA committee to determine the need for further audits and /or action plans.

5. Corrective action will be completed by 04/20/2016.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 49E151 | A. BUILDING ______ B. WING ______ | 03/10/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LITTLE SISTERS OF THE POOR** | **1503 MICHAEL ROAD RICHMOND, VA 23229** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 514 | Continued From page 47 | F 514 | | |

physician's order which read: "weight (sic) resident once weekly and record. every night shift every Mon (Monday) for assessment."

Review of the Medication Administration Record (MAR) for February 2016 revealed the order transcribed as ordered by the physician with nurses initials documented on 2/1, 2/8, 2/15, 2/22, and 2/29/16. No weight results were documented on the MAR. Review of the "Weights and Vitals Summary" section of the clinical record revealed documented weight results for 2/1 and 2/22/16. There were no results documented in the clinical record for 2/8, 2/15 or 2/29/16.

Review of the MAR for March 2016 revealed the order transcribed as ordered by the physician with nurses initials documented on 3/7/16. No weight results were documented on the MAR. Review of the "Weights and Vitals Summary" section of the clinical record revealed a documented weight result for 3/7/16.

On 3/9/16 at 2:35 p.m., missing weight documentation was reviewed with the Licensed Practical Nurse-Clinical Coordinator (LPN-A). When asked about documenting weights on the MAR, LPN-A explained that clicking on the MAR does not bring the nurse to another screen to document the weight.

On 3/9/16 at approximately 5:00 p.m., the Administrator and Director of Nursing were informed of the findings. When the Director of Nursing (Admin-B) and LPN-A were asked if any information was found about the missing weight documentation, LPN-A stated they were "Not able to find weights."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 49E151 | A. BUILDING ______ B. WING ______ | 03/10/2016 |

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|---|---|---|---|---|
| F 514 | Continued From page 48 | F 514 | | |

An interview was conducted with Admin-B on 3/10/16 at 11:30 a.m. Admin-B presented a binder which included weights of multiple residents on one form. The weights for Resident #3 that were not documented in the clinical record were on the forms presented. When asked about the documentation process, Admin-B stated the "Process is CNA's (certified nursing assistants) get the weights, document on form and give to the nurses." She stated "The nurses document the weights in the computer." When asked if the missing documentation was a documentation error, Admin-B stated "Yes."